8 are classified as being associated with microthrombocytes; and if more than 14 percent of the total number of platelets are large forms, the disorder is classified as associated with macrothrombocytes. Although this novel approach is of great interest, its quantitative aspects will need further clarification and more precise definition. More consideration and emphasis might be given to the number of *normal* platelets in the samples under study. There are many clinical conditions not associated with abnormalities in platelet function in which the percentage of large forms far exceeds 14.

The problem of hemorrhage in uremia has been considered in some detail. This discussion is both timely and time-worn. We would suggest that chronic renal disease is representative of several situations in which the correlation between abnormal *in vitro* laboratory tests and clinically significant bleeding leaves something to be desired. Uremic patients who show such defects as poor platelet aggregation or abnormal prothrombin consumption may never develop a bleeding tendency in the course of their disease. Furthermore, the majority of patients studied thus far were not actively bleeding at the time of evaluation. Since dialysis has been shown to correct the abnormal laboratory findings, it now seems clear that the various toxic-metabolic products which accumulate in uremic plasma can interfere with *in vitro* and possibly *in vivo* platelet function. We find it difficult to incriminate only one of the many toxic agents in uremia as being responsible for the hemostatic defect. Finally, it should be mentioned that thrombocytopenia should not be overlooked as a factor contributory to the impaired hemostasis in uremia.

The newly characterized platelet disorder known as "storage pool disease" (also called "familial ADP release dysfunction") is discussed. The non-metabolic adenine nucleotide storage pool is diminished in the platelets of these patients, and thus aggregation in response to agents like ADP, collagen and epinephrine is defective, particularly with regard to the "second wave" which is dependent upon release of intrinsic ADP from the platelets. In Dr. Sahud's scheme of classification, the disorder appears to be characterized by the presence of small platelets in addition to the aforementioned defects. Although there is some superficial clinical resemblance to the defect produced by aspirin, there is a difference in the mechanism involved. Following aspirin ingestion there appears to be a "block" in the release of ADP from the storage pool. These patients actually show a quantitative decrease in this storage pool; and thus if they ingest aspirin they would theoretically superimpose another defect upon the preexisting one.

It is worth while to emphasize the closing remarks of Dr. Sahud's review. Before a diagnosis of a platelet disorder is definitively made, all other more common causes of a hemorrhagic disorder should be ruled out, and the *in vitro* tests should be repeated at least once under conditions of drug abstention.

AARON J. MARCUS, M.D.
Chief, Hematology Section
New York VA Hospital
Associate Professor of Medicine
Cornell University Medical College
New York City

Health Care in the Decisive 1970's

Where We Stand and Some Lessons

ONE-FIFTH OF THIS IMPORTANT and decisive decade for health care has now passed. An assessment of where we stand seems in order and there may be some lessons to be learned. At first glance at least, the problems seem still to be major and the progress toward their solution so far relatively minor. There seems to be a growing awareness of the enormity of the task this nation has set for itself in health care, and the overall approach seems to be a little more cautious and conciliatory than sometimes was the case in the past. There seems to be a trend away from actions which seek to impose the will of one group upon others, and toward collaborating to find solutions which will be workable and reasonably satisfactory to all concerned. But so far this is only a tendency. The need for real collaboration has yet to be fully perceived in many quarters, and the mechanisms which will be necessary to accomplish it have yet to be devised.

For example, the philosophical approaches of conservatives, liberals, and radicals alike to the problems of health care delivery seem to be

softer. No longer does it mean much to say that health care is available and that anyone who needs it can get it, or that health care should be provided for the less fortunate segments of our society in the form that someone else thinks is good for them, or to say that the whole system is so rotten and inefficient that it should be completely destroyed and a new start made. Nor can those who hold any of these views any longer afford to maintain that they and only they are right and everyone else is wrong. These realities are now only just beginning to be perceived and their implications for a new collaboration among all those properly concerned in health care, including government, have yet to be widely recognized.

The records of those who have tried to solve the problems of health care delivery have so far not been very good. Some would have us copy one or another of the systems used in foreign countries but this has not attracted much support. The efforts in public health circles to subsume health care delivery into public health have not succeeded. The prepaid closed panel group practice advocates have earned a degree of acceptance but their plans have not swept the country. Hospital-based prepaid plans do not seem to have caught on to any extent. Medical Society sponsored foundations for health care seem to be gaining ground but these too have not yet found themselves on the crest of a wave. Perhaps this is because physicians, whose active participation is essential to these programs, are always reluctant to surrender any of their independence or freedom of action to anyone. Government programs to date have seldom been as effective as their sponsors had hoped, with the possible exception of Medicare (Title XVIII of the Social Security Act) which has actually worked out somewhat better than many expected it would. Some kind of national health insurance now seems likely to be enacted, and what this will be like and whether it will be workable and satisfactory to consumers, providers, payors and government, and whether it will actually make more or less health care services available to the people of this nation remains to be seen. The chances of success would seem greater, however, if those who must carry out the plan and render and receive its benefits, were more in evidence in the developmental processes which must now be taking place.

The emphasis of government so far in the 1970's seems to be more upon the quantity and less upon the quality of health care services. In fact the California State Plan for Health actually redefines quality more or less in terms of quantity and distribution of services. This emphasis is also to be seen in the extent to which governmental support of medical schools has become more and more conditional upon increasing the quantity even at the expense of the quality of the product, as when premiums are offered to medical schools for graduating more students and for doing this more quickly with a shorter curriculum. One may suspect that here again a single segment of society—this time the federal bureaucracy—is deciding what it thinks is best for the rest of society and trying to impose its will with little or no collaboration with those segments which will be affected both in the short and long term by the actions taken.

The 1970's so far have found no real solution to the problems of rising costs of health care services. It has become all too evident that rising costs have been an inevitable result of success in rendering more services of higher quality to more people, of success in eliminating debasing charity for patients, and of success in raising the wage scales and working conditions of those in health care so as to achieve parity with workers in other fields. Obviously, neither the degree of success nor the amount of the cost was anticipated. So far, approaches to reducing costs have been both crude and paradoxical. For example, at the national level funds for research have been diverted in order to provide more services. The effect of this is to reduce research into the cause, nature and eradication of illness and injury, and into the cost benefit and cost effectiveness of various health care services, both of which might in time reduce costs significantly, while at the same time increasing costs by providing more services for more people which more research might indicate they may or may not need. And at the state level both the number and type of services for the needy were arbitrarily curtailed by fiat. This quite ruthless approach was subsequently struck down by the court. More rational, realistic and sophisticated approaches to the problems of costs are clearly needed.

It is suggested that among the lessons to be learned from the experience so far is that no

single philosophical approach and no single segment of health care, including government, can alone develop approaches or solutions to health problems and then impose them on the rest without the risk of costly disruption and general dissatisfaction. Just as consumers have clearly indicated they must be part of the planning, operation and evaluation of services if they are to accept them and be satisfied, it will surely be found that physicians, other providers, payors and many other elements of the health care industry will also have to be involved if they too are to accept the services and be satisfied. Dissatisfaction and nonacceptance, whether of providers or consumers, can be disruptive, costly and counter-productive of the goals everyone seeks to achieve. If all this is true, as seems likely, and if it is not generally perceived for some time, which also seems likely, then there will be a further period of blundering, bludgeoning, dissatisfaction and waste until the necessity is recognized for new and much more collaborative approaches to planning, operations and evaluation for health care delivery programs and systems which will enable not only consumers, but physicians, other providers, payors and all who are properly concerned to be properly involved. It is suggested that recognizing this, which must be done, and developing the means to do it are now most pressing problems which should be highest on the health care agenda for the next year or two of this decisive decade.

—MSMW

Gastroduodenal Stress Ulcers

THE SPECIALTY CONFERENCE from UCLA on gastroduodenal "stress" ulcers [page 32] serves to emphasize the obscure and diverse etiology of these lesions as well as the difficulties encountered in treating them. Stress ulcers are a form of peptic ulceration and occur in patients already desperately ill as a result of injuries, operations or trauma to the brain; thermal burns; or acute, severe illnesses. Perhaps it is more precise to refer to these lesions as acute peptic ulcers associated with stress or as Doctor Schwabe stated, "the stress ulcer syndrome." Peptic ulcers occurring with stress more often are located in the stomach than the duodenum, are frequently multiple, and are most likely to bleed or perforate. Furthermore, except when the ulcers occur with central nervous system lesions, most of the patients do not have gastric hypersecretion.

It is likely that a variety of causes or combinations of circumstances are involved in the acid-peptic digestion occurring in stress ulceration and that these operative factors vary from one patient to another. Although the precise cause of the peptic ulceration or erosion is not known, the results of these lesions are well enough understood to allow a rational approach to diagnosis and treatment.

Theoretically, stress ulcers may be prevented in some instances by the recognition and treatment of predisposing causes. In the clinical setting of a poor risk patient severely traumatized or chronically stressed, a prophylactic ulcer regimen, without the administration of anticholinergic drugs, may be helpful. Once bleeding becomes manifest and the nature of the lesion is established, both the surgeon and the gastroenterologist should collaborate to determine the best mode of management in each case. Although many of the patients are exceedingly poor operative risks, it should be remembered that they likewise sustain hypovolemia and continued bleeding equally poorly. Lucas et al[1] found that of more than 300 patients who had significant bleeding, over 80 percent responded to ice-saline lavage of the stomach and only 38 required operative intervention. I believe that the indications for operative treatment when bleeding continues are similar to those when gastrointestinal hemorrhage is due to other causes. Dunphy and Hoerr[2] in 1948 emphasized that the timing of operation in patients with acute gastrointestinal hemorrhage is related to the rate of bleeding as manifested by the response to transfusion. They found that if the blood pressure could not be stabilized initially by the administration of 2000 ml of blood or if after stabilization it was necessary to transfuse more than 1000 to 1500 ml daily, the patient was unlikely to respond and prompt operation was indicated. These same criteria seem as important now as they were then.

In the Specialty Conference, Doctor Clarke clearly outlined the variety of operative procedures employed to treat patients with massively